

**STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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Mr. Chairman and Members of the Committee:

On behalf of the more than 1.3 million members of the Disabled American Veterans (DAV) and its Auxiliary, I wish to express my appreciation for this opportunity to present the views of our organization on health care legislation before the Subcommittee.

The DAV is an organization devoted to advancing the interests of service-connected disabled veterans, their dependents and survivors. For the past eight decades, the DAV has been devoted to one single purpose: building better lives for our nation's disabled veterans and their families.

The measures before the Subcommittee today cover a range of issues important to DAV, to veterans and their families. My testimony includes a synopsis of each of the bills you are considering, along with DAV's position or other commentary. We ordered our testimony numerically by bill in the same way you listed the bills in your letter inviting our testimony.

We have previously testified that through their extraordinary sacrifices and contributions in military service, veterans have *earned* the right to the Department of Veterans Affairs (VA) health care as a continuing cost of national defense. Moreover, we adamantly believe America's free citizens, as beneficiaries of veterans' service and sacrifices throughout our history, desire that the government fully honor its moral obligation to provide quality and timely health care services to wartime service-connected disabled veterans.

This Subcommittee is aware the DAV is opposed to any initiative that would turn VA into a primary insurer rather than a provider of health care to veterans. We believe VA must use its resources to maintain the base of its health care services, which is provided through and by VA health care facilities and health care providers. This current form of VA health care has served well to the benefit of all veterans, offers an uninterrupted flow of services to veterans in need, and ensures the quality of those services. VA is well recognized as America's best health care value, with the lowest error rates, highest satisfaction rate and lowest cost. Why would Congress want to contract out some of those services, at higher error rates, lower satisfaction, and higher cost?

Notably, VA currently spends \$2 billion or more each year on contract health care services, from all sources. Unfortunately, as VA's contract workloads have grown significantly, it has not been able to monitor this care, consider its relative costs, analyze patient care outcomes, or even establish patient satisfaction measures for most contract providers. VA has no systematic process for contracted care services to ensure that:

- care is safely delivered by certified, licensed, credentialed providers;
- continuity of care is sufficiently monitored, and that patients are properly directed back to the VA health-care system following private care;
- veterans' medical records accurately reflect the care provided and the associated pharmaceutical, laboratory, radiology and other key information relevant to the episode(s) of care; and
- the care received is consistent with a continuum of VA care.

The DAV is deeply concerned that any bill seeking to contract for care outside VA without addressing these concerns would essentially shift medical resources and veterans from VA to the private sector to the detriment of the VA health care system and eventually sick and disabled veterans themselves. Any proposal to contract for care with non-Department facilities and providers would encourage VA to refer patients, and thereby spend dollars for their care outside a system that is specifically created for veterans. Such a proposal sets a dangerous precedent that, if allowed to expand, could endanger VA facilities' ability to maintain a full range of specialized inpatient and outpatient services for all enrolled veterans. It would erode Veterans Health Administration's (VHA) patient resource base, undermine VHA's ability to maintain its specialized service programs, and endanger the well being of veteran patients under care within the system.

This Subcommittee is well aware of the funding crisis VA health care is experiencing and its impact on sick and disabled veterans who depend on VA's specialized programs. In the years since open enrollment was terminated, VA has been forced to do more with less. Even though over the past two budget cycles, Congress has provided increased discretionary appropriations for veterans' health care, the funding levels have not kept pace with VA's current services costs and the steady and significant increases in demand for services from enrolled veterans. If given sufficient funding on time to meet the growing need of all enrolled veterans' health care, including rural veterans, VA should be held accountable for meeting demand in a timely manner. Only as a last resort would we want care to be contracted out. Moreover, if VA timely receives adequate appropriations, it should be expected to plan for the appropriate number of staff, infrastructure, and other resources necessary to provide veterans medical care in a cost-effective manner.

H.R. 92

The stated goal of this bill is to provide timely access to VA health care. To accomplish this, a 30-day standard would be established as the maximum length of time that a veteran would have to wait to receive an appointment for primary care in a VA facility. It would also direct VA to establish a standard for the maximum length of time that a veteran would have to wait to actually see a provider on the day of a scheduled appointment. Under the bill, if the Secretary found that any particular VA geographic service area failed to substantially comply with the time standards, facilities in that area would be required to contract for the care of a veteran in each instance in which facilities would be unable to meet those standards. The contracting requirement would be mandatory for veterans who are classified within enrollment Priority Groups 1 through 7, and discretionary for those within Priority Group 8.

The bill would require the Secretary to carry out a one-time examination of waiting time data for the entire system, stratified by geographic service area. The Secretary would be required to issue a determination regarding compliance with the standard in each geographic service area. If the compliance rate for any area were below 90 percent, then facilities located in that area would be subject to the requirement that they contract for care whenever they are unable to meet those standards. The bill would also require that the Department of Veterans Affairs (VA) submit a variety of reports to the Committees on Veterans' Affairs concerning the purposes of the bill.

In addition, the bill's language pertaining to the payment mechanism VA would use for outpatient services provided under the terms of the bill is unclear. Specifically, if VA's reimbursement rate were linked to current policy under Part B of the Medicare program, VA would be required to pay private providers 80 percent of the scheduler fee amount for which Medicare is ordinarily responsible. Under Medicare, beneficiaries must meet an annual Part B deductible for all outpatient services. Participating physicians under the Part B program can only receive equitable reimbursement for services rendered by invoicing Medicare beneficiaries the remaining 20 percent of the scheduler amount, and collect deductibles for given services or procedures.

DAV has a longstanding legislative resolution stating our firm opposition to co-payments in VA health care. Under this measure, if a non-Department facility or provider were to receive the standard 80 percent of the fee schedule amount for which Medicare pays for a particular service, and they are forbidden to bill the veteran for any difference between the billed charges and the amount paid by VA, then, we believe this may act as a strong disincentive for private health care providers to accept and treat veterans under this authority, frustrating the very purposes of the bill.

Mr. Chairman, this Subcommittee held a thoroughgoing legislative hearing on September 30, 2003 (Serial No. 108-24) to consider an earlier version of this same bill. Among the statements made at that hearing was the following, by the then-Under Secretary for Health, Dr. Robert Roswell:

"My concern is that in the long run, I believe veterans are better served if we build a system of care that will address their needs, not leave it up to geographic location or a particular clinic that they might choose to use to determine what their health care benefit is on any particular day or any particular month. Ultimately, I think we have to build the system that addresses those needs. And purchasing care, because we are frustrated with waiting times, may not be the best way to do it. It might be, I don't know. I think we have to explore that in greater detail. I do believe there are a number of things that this committee could do to enhance veterans' access to care. And I appreciate the leadership of the committee in seeking those issues."

The Subcommittee apparently agreed with Under Secretary Roswell. After considering all the views of witnesses and Members, and reviewing a series of policy issues raised by that bill, the Subcommittee took no further action on that bill for the duration of that Congress. We do not believe circumstances have changed since that time that would warrant this Subcommittee to take any action on the bill now. While we appreciate that on its surface this bill would seem helpful in the short run to some veterans, its probable but unintended destructive consequences demand that we oppose it.

H.R. 315

This bill would expand VA's existing authority to contract for private health care by redefining "geographic inaccessibility" through the use of population density markers and highway mileage distance from VA facilities. Under the bill, if a veteran's home of residence met a given inaccessibility standard, the Secretary would be required to permit that veteran to receive private health care for primary care, acute or chronic symptom management and for "nontherapeutic medical services." Most likely the Congressional Budget Office would conclude this bill constitutes mandatory spending under the PAYGO policy of the House.

As indicated in many other forums including this one, DAV supports passage of mandatory, guaranteed or assured VA funding to ensure sick and disabled veterans receive adequate VA health care, but we do not support mandatory funding for private providers to care for veterans via a VA insurance function. Thus, similar to H.R. 92, we do not support this bill.

H.R. 339

This bill would require the Secretary, in the case of a VA facility with a waiting list of six months or greater, to provide for any veteran so informed of that waiting period, contract services by private providers under the same terms and conditions as those services would be provided in a VA facility.

DAV opposes this bill for the same reasons we are concerned about the two earlier bills dealing with access. Insufficient resources is a primary cause of delayed access to care. This can be surmounted with new resources. This measure, like the others similarly aimed, would exacerbate VA's problems by stripping it of what limited resources it possesses to care for the patients now in the VA system, making its rationing and waiting lists even worse.

H.R. 463

This bill would legislatively moot Title 38, section 1705, thereby rescinding the Secretary's authority to establish and operate a system of annual enrollments for VA health care, and it would make every American veteran entitled to enrollment for VA health care on request. Over 1,000,000 veterans have unsuccessfully attempted to enroll in VA health care since the cut-off of enrollments for Priority 8 veterans occurred in 2003. While we certainly support the proponent's premise that every veteran who wants it should be able to enroll in VA health care, without a major infusion of new funding, enactment of this bill would worsen VA's financial situation, not improve it, and would not serve veterans well. We recommend the Subcommittee defer action on this bill until after Congress enacts mandatory, guaranteed or assured funding for VA health care.

H.R. 538

This bill would establish a requirement for a special study of the needs of veterans in 24 counties of "Far South Texas," with the goal of establishing either a public-private venture, a full service VA facility, or a shared VA-military facility to meet their health care needs.

In accordance with our Constitution and Bylaws, the DAV's legislative agenda is determined by mandates formed by resolutions adopted by our membership. We have no resolution specific to the provisions of this measure. While we have some concerns about whether this bill would contravene the results of the recent Capital Assets Realignment for Enhanced Services (CARES) process in one particular geographic area, to the exception of all others, we take no official position on its passage.

H.R. 542

This bill would require VA mental health counseling to be provided in languages other than English when veterans are not English-proficient. The bill would also require the VA Secretary to ensure the purposes of Executive Order 13166, dealing with English as a second language among federal beneficiaries, are carried out.

Again, we have no resolution relevant to the provisions of this measure; however, its purposes appear beneficial and therefore DAV would not oppose passage of this measure.

H.R. 1426

This bill would empower an enrolled veteran to elect to receive VA health care from private sources. Under its terms, the Secretary would have no discretion to deny such an election once it was made. The bill would also provide a medication benefit to all enrolled veterans for the dispensing of VA pharmaceuticals based on prescriptions written by private physicians. For similar reasons supporting our opposition to H.R. 92, H.R. 315 and H.R. 339, we oppose this bill.

H.R. 1470 and H.R. 1471

H.R. 1470 would expand VA chiropractic care by requiring such services to be available in at least 75 VA medical centers before the end of 2009 and available at all medical centers by the end of 2011. VA was authorized to offer chiropractic care and services under the provisions of section 204 of Public Law 107-135, the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001. We believe chiropractic care offers a valuable health care service to veterans and DAV members support the system-wide availability of chiropractic services within the VA health care system.

While we support broader availability of chiropractic in VA facilities that would be brought about by enactment of H.R. 1470, the purpose of H.R. 1471 raises concerns. This bill would establish chiropractic service practitioners on the same level as VA medical doctors in the direct provision of primary care services. Each veteran receiving care in VA is assigned a single primary care provider, a medical doctor. A VA primary care provider is part of a primary care team charged with the responsibility for addressing the health care needs of the veterans assigned to that team. Accordingly, we believe in the VA health care system, access to chiropractic services should be provided in consultation with VA primary care providers responsible for maintaining the overall health of patients assigned to them. Thus, we oppose H.R. 1471.

H.R. 1527

Similar to H.R. 315, reviewed above in this testimony, this bill would grant election to veterans living at considerable distances from VA facilities to choose private care instead of care in VA facilities. The Secretary would not be able to deny this election, and VA would be required to pay associated costs. Furthermore, this measure would provide a pharmaceutical service similar to that of H.R. 1426. DAV opposes this bill for the same reasons as we oppose the earlier measures.

Draft Bill — Veterans' Rural Health Care

The bill would require the Secretary to establish a mobile “Vet Center” pilot program in rural areas, and a pilot program for health information exchange with rural clinics, critical access hospitals and community health centers in rural areas. It would create an Advisory Committee on Rural Veterans and specify its membership and mission. The bill would establish at least four VA rural health research, education and clinical activities centers in VA medical centers in rural areas. It would amend section 2061 of Chapter 20, Title 38, United States Code, by adding the term “rural” as one of several groups defined with special needs to be addressed through VA’s homeless assistance programs. The bill would expand VA’s graduate medical educational mission into rural areas and enhance the education, training, recruitment and retention of nurses in rural areas. Finally, the bill would require a series of reports from the VA Secretary dealing with several of the matters contained in the bill.

As this committee is aware, the cost of providing care in rural and remote areas is higher than in urban settings. In much of our deliberation on this issue, we struggle to find a way to fill the indeterminate gap between limited resources and the demand for rural health care. We are hopeful the creation of an Advisory Committee on Rural Veterans and the Rural Health Research, Education and Clinical Care Centers will strive to strike the balance we seek when providing better outreach and high quality VA medical care to veterans residing in rural and remote areas. Moreover, when striving for good stewardship of taxpayer dollars we ask due consideration be given to the cost effectiveness of the Mobile Vet Center program, which is a concern for such a program serving rural areas. Much of the content of this bill is consistent with recommendations of the *Independent Budget*. Further, we believe this measure is a good first step in addressing the healthcare needs of rural veterans, thus; DAV fully supports its purposes.

H.R. 1944

The Veterans Traumatic Brain Injury Act of 2007 would require the VA to establish a screening program for all veterans of Operations Iraqi and Enduring Freedom, of the Persian Gulf War and earlier conflicts dating from 1998. The bill would require the Secretary to report the results of such screening to Congress on an annual basis. The bill would require the Secretary to establish comprehensive traumatic brain injury (TBI) rehabilitation programs in four geographically dispersed polytrauma network sites (presently centered in Richmond, Minneapolis, Tampa and Palo Alto VA Medical Centers), and to report that establishment within one year of enactment, with additional information about the veterans so served. The bill would establish a TBI transition office within each polytrauma network to coordinate health care delivery and other services. The bill would

require VA to establish cooperative agreements with other entities capable of providing appropriate services to veterans with TBI. Finally, the bill would establish a TBI registry to identify, track and communicate with, veterans suffering from TBI.

Mr. Chairman, much of the content of this bill is consistent with our review of TBI and our recommendations in the *Independent Budget* for fiscal year 2008. Clearly, TBI is going to remain a major focus of VA health care for the next several decades. Press reports indicate that over 12,000 improvised explosive devices (IEDs) have been detonated in the current OIF/OEF campaigns. This means the average soldier or marine has been exposed to concussion, possibly multiple times. VA needs to prepare for this coming health care challenge, particularly for those veterans whose exposure may be classified as “mild,” or “moderate” in nature and when no head wound resulted from that exposure. We believe this is going to be one of VA’s greatest health care challenges in the near term. This bill will aid VA in making those preparations; thus, we fully support its enactment.

In previous testimony, the DAV has raised concerns regarding the lack of effective screening and clinical assessment tools for mild to moderate TBI. While we applaud the committee for considering this bill, and we support it, we note that VA issued a directive in the past two weeks (VHA Directive 2007-013), implementing a TBI initiative that features a screening “pop up” within the VistA clinical software system. The directive also makes reference to a screening protocol and the mandatory continuing education requirement for specialized training in TBI. The directive makes no mention of the clinical assessment tool, which was the subject of a vigorous discussion at the Committee’s hearing on September 28, 2006. We understand that earlier this year, VA established a clinical task group to develop that clinical assessment tool, and we urge the Subcommittee to closely monitor this development to ensure that tool is put into the hands of VA practitioners at the earliest possible time.

Furthermore, we recommend greater flexibility be afforded to the Secretary regarding the number of locations for which the comprehensive program for long-term traumatic brain injury rehabilitation shall be carried out, such that if the need arises to expand the program, the current language limits VA’s ability to meet that need. Also, the legislative language for eligibility of a veteran to receive care under this program may preclude veterans suffering from service-connected TBI. Finally, a provision of this measure encourages the Secretary to provide the comprehensive program for long-term traumatic brain injury rehabilitation through cooperative agreements with appropriate public or private entities. We are cognizant of the opportunities a cooperative agreement may offer but left undefined as currently written, we are concerned that this provision may overtime erode VA’s special emphasis program of TBI care.

Mr. Chairman, this concludes my testimony. I and other members of the DAV Legislative Staff will be pleased to make ourselves available to you and your staffs for further discussion of our positions on any of these issues, in hopes of working toward compromise on measures that we can eventually support. Thank you for asking DAV to testify today. I will be pleased to respond to any of your or other Committee Members’ questions.